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COMMUNITY MENTAL HEALTH SYSTEMS

Transforming Systems of Care: The American Association of Community Psychiatrists Guidelines for Recovery Oriented Services

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ABSTRACT: Thinking about recovery has grown significantly over the last 70 years, and particularly in the past fifteen. Promotion of recovery has recently been recognized as an organizing principle for the transformation of behavioral health services. Recovery is a personal process of growth and change which typically embraces hope, autonomy and affiliation as elements of establishing satisfying and productive lives in spite of disabling conditions or experiences. Recovery oriented services replace paternalistic, illness oriented perspectives with collaborative, autonomy enhancing approaches and represent a major cultural shift in service delivery. Recovery oriented services replace the myth of chronicity and dependence with a message of individualism, empowerment and choice in the context of collaborative relationships with service providers. The American Association of Community Psychiatrists has developed *Guidelines for Recovery Oriented Services* to facilitate the transformation of services to this new paradigm. The guidelines are divided into three domains: administration, treatment, and supports, each consisting of several elements for which recovery enhancing characteristics are defined. Several example indicators are also provided for each element. This paper presents these guidelines and discusses their application.

KEY WORDS: recovery; empowerment; consumer movement; collaboration; system transformation.

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INTRODUCTION

Concepts of "Recovery" have recently gained momentum in their trajectory toward becoming the predominant means for organizing and delivering behavioral health services (Iglehart, 2004; Jacobson & Curtis, 2000; New Freedom Commission on Mental Health, 2003; Office of the Surgeon General, 1999). While the value of these ideas has only recently been broadly recognized within our systems of care, many aspects of currently recognized recovery principles have been with us for sometime.

HISTORICAL PERSPECTIVE

The idea of recovery has been a mainstay of the addiction community for many years. It has its roots in the 12-step movement that began in the 1930s (Alcoholics Anonymous World Service, 1976; White, 1998). It became clear to the founders of Alcoholics Anonymous that overcoming the disease of addiction was much more than establishing abstinence. They recognized that addictive disorders create thought processes and conditioned responses that are far more powerful than the physiological manifestations of dependence. The 12 steps and the various slogans related to thought processes common in persons with addictions are all related to current concepts about recovery.

Although recovery has had a less prominent role in the mental health community in the past, it has been part of the scene for nearly as long as it has been part of the addiction field. Abraham Low, MD, a psychiatrist, began developing recovery-enhancing techniques in 1937, and by 1952, Recovery, Inc was established (Low, 1950; Sachs, 1997). Recovery, Inc. is an organization run by mental health consumers that employs many of the ideas developed by Dr. Low. It offers a peer assisted healing program that focuses on changing thought processes, developing autonomy, and regaining productive and satisfying lives. Like the 12-step approach, it attempts to empower people to take responsibility for managing their illness or disability. Recovery, Inc. has recognized the value of developing a partnership with helping professionals and has promoted this model (Galanter, 1988; Murray, 1996).

RECENT DEVELOPMENTS

Recovery has grown in its breadth and stature over the last 15 years. Contributing to its ascension has been the consumer-survivor movement

(Chamberlain, 1984, 1990; Fisher, 1994a), the development of psychiatric rehabilitation (Anthony, Kennard, O'Brien, & Forbess, 1986; Anthony & Liberman, 1986; Munich & Lang, 1993), and an improved understanding of how change occurs (DiClemente, Schlundt, & Gemmell, 2004; Linehan, 1993; Miller & Rolnick, 1991; Sowers, 1997). Research has indicated that majority of people with severe behavioral health disabilities do have success in establishing recovery, many of them without professional assistance (Harding, 1987; Harding, Zubin, & Strauss, 1987). With this broadening of the understanding of the recovery process, there has been growing recognition of its value and power for individuals and for systems that serve people attempting to overcome significant problems. As the treatment community becomes more aware of the myth of chronicity, the need for a transformation of service systems is more apparent. This was pointed out most prominently with the release of the President's New Freedom Commission Report in 2003. It clearly indicates the need to move toward consumer and family driven services that offer hope and dignity to persons struggling with behavioral health disorders (New Freedom Commission on Mental Health, 2003; Onken, Dumont, Ridgeway, Doman, & Ralph, 2002).

TRANSFORMATION TO RECOVERY BASED SERVICES

Recovery has often been described as a universal process; its principles can be applied by virtually anyone attempting to change. Although it has been variably defined, most conceptualizations recognize that recovery is a highly personal process and one that may continue throughout a person's life. Most definitions of recovery include several of the following elements (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Deegan, 1998; Fisher, 1994b; Mead & Copeland, 2000; White, 1998):

-Hope and faith
-Self-management and autonomy
-Restoration and personal growth
-Tolerance and forgiveness
-Adaptability and capacity to change
-Personal responsibility and productivity
-Peer support and community life
-Dignity and self-respect
-Acceptance and self awareness
-Honesty, humility and trust

The consumer movement has created a demand for recovery oriented services in many areas of the country, and this has often been critical in creating an impetus for system change (Jacobson & Curtis, 2000; Curtis, McCabe, & Montague, 1991; Roth, Lauber, Crane-Ross, &

Clark, 1997; New Mexico Human Services Department, 2004). Despite these inroads, the majority of services in our country continue to practice more traditional models of service delivery, and many of the consumers of behavioral health services remain unaware of the promise of recovery and its potential for improving the quality of their lives.

The movement toward recovery models provides an opportunity for service systems to discard practices that may inadvertently impede their constituent's ability to realize their potential (Anthony, 1993, 2000). The transformation of systems from a paternalistic, illness oriented perspective to collaborative, autonomy enhancing approaches represents a major cultural shift in service delivery. Traditional professional training has developed a workforce that has seen its role as a benign authority providing care for persons with severe, unremitting illnesses, unable to make rational decisions independently. It has viewed their illnesses categorically, rather than individually, and as a result, services have been designed to meet the needs of a group, into which individuals must fit. Professionals have been trained to have limited expectations for lasting improvement and therefore, little hope has been offered to clients to establish a productive and satisfying life. Training has often emphasized avoidance of personal involvement and self-disclosure and maintenance of fairly rigid boundaries in professional and non-professional roles. These traits have tended to divide professionals from persons seeking assistance and have hindered collaboration, mutuality, and reality based relationships (Fisher, 1994a; McCubbin & Cohen, 1966).

If recovery is at least partly defined by a process of change and growth, then service delivery systems can think of this proposed transformation as a process parallel to an individual's recovery. It is an extremely challenging task that requires vigilance, dedication, skill, patience, humility and a great deal of hard work. It also requires open mindedness and willingness to accept help. The assistance of persons in recovery as partners in this process will allow the development of systems of care that will assure that all individuals have every opportunity to reach their full potential.

DEVELOPMENT AND USE OF THE GUIDELINES

The Guidelines for Recovery Oriented Services were developed by the Quality Management Committee of the American Association of Community Psychiatrists. The committee is composed of psychiatrists

working primarily in the public sector with extensive experience in a variety of clinical settings with multi-disciplinary teams and often in partnership with advocacy groups. These Guidelines were developed through clinical consensus and literature review in consultation with system stakeholders. Once developed, the Guidelines were distributed for review and were revised according to feedback received.

These guidelines are intended to facilitate the transformation to recovery-oriented services and to provide direction to organizations or systems that are engaged in this process. They should be useful to systems that have already made significant progress in creating services that promote recovery by providing a systematic way of thinking about quality improvement and management for these services. The guidelines are organized into three domains of service systems: administration, treatment and supports. Each domain is composed of several elements and recovery-enhancing characteristics for each of these elements are described. Indicators included with each element are intended to provide a template for systems wishing to develop measurement processes, and may be customized to meet specific circumstances unique to localities. In many cases, however, further refinement or quantification will not be necessary.

RECOVERY ORIENTED SERVICES QUALITY DOMAINS

Administration

Mission and Vision – Strategic Plan. Commitment to processes fostering recovery must be clearly articulated for organizations to successfully pursue and maintain recovery-oriented services (ROS). The organizational mission should commit to the vision that individuals with mental illness can reorient their lives to a recovery process. Professionals must articulate the goal of developing and strengthening the community of recovering persons. Strategic planning will include a focus on achieving the mission of strengthening the community of recovering persons (Anthony, 1993; Schmook undated).

INDICATORS

A) Development of mission and vision statements articulating organizational commitment to recovery and a process for achieving recovery oriented services.

B) Organizational review and strategic planning process that incorporates diverse viewpoints from the community of service users.

Organizational Resources. Organizational structures responsible for oversight of recovery oriented services must be empowered and supported through the highest levels of the organization to create a political environment that is conducive to the development of these services. This should be manifest at least in part, through the provision of adequate financial resources to meet the requirements of such programming. This would include funding to ensure ample consumer participation in administrative processes governing the organization (i.e., by providing appropriate compensation for their expert contributions) and to create employment opportunities for consumers to enhance ROS (Mueser et al., 2002; Simpson & House, 2002).

INDICATORS

A) Annual budget insures adequate resources to support consumer participation in administrative processes.
B) Significant representation of persons in recovery on organization's treatment and support staff.

Training – Continuing Education. Adequate understanding of recovery concepts and of consumer perspectives and aspirations, by professionals working in service delivery systems is essential to the implementation of ROS. Ensuring that professionals have adequate exposure to consumers in non-clinical settings should be a significant goal of orientation, training, and continuing education programming. Professionals must have exposure to recovery models in their Continuing Education programs. Training standards and competency requirements should reflect this value (Fisher, 1994a; Onken et al., 2002; Roe, Weishut, Jaglom, & Rabinowitz, 2002).

INDICATORS

A) Processes developed for interactions and/or communications between consumer and providers in non-clinical settings.
B) Establishment of core competency standards regarding knowledge of recovery principles.

Continuous Quality Improvement. Continuous Quality Improvement (CQI) programming assumes that those most intimately involved with the activities and services of the organization are in the best position to identify improvement opportunities and to develop and evaluate plans to take advantage of them. ROS providers that incorporate users of services into the governance of their agency/organization will naturally integrate consumers into quality improvement processes at all levels. Consumer involvement in CQI projects as equal partners should be supported through adequate compensation of consumer participants for the services they provide, just as it is for professional participants. This approach provides an important way to empower individuals and to foster investment in the services they receive by recognizing the value of collaboration in establishing stable recovery environments (Chowanec, 1994; Simpson & House, 2002; Torrey & Wyzik, 2000).

INDICATORS

A) Processes in place to ensure that consumers are included in CQI activities as equal partners with professionals.
B) Agency budgets will reflect compensation for consumer involvement in CQI activities.

Outcome Assessment. As behavioral health services become more accountable to the outcomes they produce, recovery oriented services will develop indicators that relate not only to concrete levels of function, but also to variables related to an individual's progress in recovery and personal growth. These somewhat qualitative and often abstract aspects of experience should be translated into quantifiable and measurable constructs that will provide evidence for quality of life as a valid aspect of service outcome (Bigelow, Gareau, & Young, 1990; Friese, Stanley, Kress, & Vogel-Scibilia, 2001; Mueser et al., 2002; Simpson & House, 2002; Resnick, Rosenheck, & Lehman, 2004; Roth, Crane-Ross, Hannon, & Hogan, 1999).

INDICATORS

A) Outcome indicators will include items related to quality of life, recovery and self fulfilling function.
B) Identification and use of standardized quantification scales for recovery elements

C) Established process for consumer participation in developing outcome indicators for progress in recovery.
D) Outcome measurement processes are used to improve services and programs

Treatment

Service Arrays. A variety of services that support consumer self-sufficiency and decision-making should be available in comprehensive service systems. Available services should include flexible options for individual and group psychotherapy, rehabilitation and skills building opportunities, various intensities of empowering case management, crisis management and hospital diversion plans participatory psychiatric medication management. Prevention, health maintenance, and disease self-management principles should provide the guiding philosophy for all clinical services (Macias, Barreira, Alden, & Boyd, 2001; Mueser et al., 2002; Roth et al., 1999).

INDICATORS

A) Integration of consumer, family and peer supports, disease management education and crisis management planning will be reflected in policy and procedure documents.
B) Establishment of services supportive of recovery processes and which incorporate self management principles
C) Recovery oriented service design will be reflected in policy and procedure documents, including financial structures that encourage such service development
D) Consumers and family members are enlisted to participate in the decisions regarding resource allocation and service development.

Advance Directives. Encouraging and facilitating the completion and utilization of advance directives by service users is an important process in creating a recovery-oriented environment. Advance directives provide a method to respect the wishes of consumers should they become incapacitated at some future time. Providing adequate information for consumers to make informed decisions when they are capable of doing so is a critical aspect of the process (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; NMHA News Release, 2002; Srebnik, Russo, Sage, Peto, & Zick, 2003).

INDICATORS

A) Established process for obtaining informed advance directives from consumers during periods of relatively healthy function.
B) Established process for review of advance directives during periods of relapse/incapacitation.

Cultural Competence. Culturally sensitive treatment and services indicate respect for individuals and recognition that beliefs and customs are diverse and impact the outcomes of recovery efforts. Access to service providers with similar cultural backgrounds and communication skills supports consumer empowerment, autonomy, self-respect, and community integration (Dixon, Krauss, & Lehman, 1994; Felton et al., 1995; Onken, Dumont, Ridgeway, Doman, & Ralph, 2002; Smith, Buxton, Bilal, & Seymour, 1993; Westermeyer, 1999).

INDICATORS

A) Development of treatment staff with an ethnic/racial profile representative of the community being served
B) Established cultural competency standards for organization's staff.

Planning Processes. Respect for consumer participation and efforts to obtain meaningful input from them will be a hallmark for ROS. This input should be solicited even when consumers are most debilitated and opportunities to make choices should be provided whenever possible. ROS will emphasize consumer choice in all types of planning processes including, but not limited to treatment, service, transition and recovery plans. ROS will emphasize the identification and use of a person's strengths to design a plan to overcome their difficulties (AAAP/AACP Joint Task Force, 2002; AACP, 2001; Copeland, 1997; Kauffman, Freund, & Wilson, 1989).

INDICATORS

A) Development of collaborative process for developing continuous comprehensive service plans between consumers and providers.

B) Efforts to engage more impaired clients are reflected in agency planning records
C) Process in place to inform consumers of treatment/service options and to discuss pros and cons of each prior to service plan development.

Integration – Addiction and Mental Health. Recovery-oriented services (ROS) will value and promote holistic approaches to health maintenance and recovery development that recognize the impact and interaction of co-occurring illnesses and the need to address them concurrently. Principles of recovery can be applied to diverse processes that disrupt health and can provide a common thread by which the return to health may be orchestrated (AACP, 2000; Drake et al., 2001; Mueser, 2002; Sowers, 1997).

INDICATORS

A) Integration of mental health and substance abuse programming is reflected in agency activities.
B) Establishment of recovery principles as unifying concepts in provision of holistic mental health, physical health and addiction services.
C) The presence of co-occurring substance and mental health disorders is reliably detected through screening processes.
D) Development of well coordinated referral procedures to collaborative agencies for effective parallel treatment of co-occurring disorders. (If integrated services are not available.)

Coercive Treatment. The use of coercive measures for treatment is not compatible with recovery principles. Therefore, providers of ROS will make every effort to minimize or eliminate the use of coercive treatments to the greatest extent possible. When coercive treatments are unavoidable, they should be used with great care and circumspection. Involuntary treatment arrangements should occur in the least restrictive environments possible to meet the needs of disabled individuals and maintained for the shortest period of time possible. Individuals must be treated with compassion and respect during episodes of incapacitation and should be offered choices to the greatest

extent possible with regard to their treatment plan. Attempts to transition to voluntary treatment status should be strongly encouraged to assure that recovery principles might be restored to treatment processes (AACP, 2001; Davis, 2002; Onken et al., 2002).

INDICATORS

A) Appointment of consumer advocacy liaisons to courts and involuntary treatment authorities
B) Development of strategies to engage and empower clients on involuntary status that are incorporated into treatment plans and agency programming.
C) Demonstration of reduction in the use of coerced treatment options over defined periods.

Seclusion and Restraint. The use of seclusion and restraint should be used only in extreme situations where safety is threatened. When necessary, seclusion should be kept to a minimum, should be implemented in the most humane manner possible, and processes to assure that these measures are discontinued as soon as possible should be developed. Debriefing for all individuals involved in the incident should be required and effective quality monitoring and improvement processes should be in place (Currier & Allen, 2000; Fisher, 1994b; Joinkas, Cook, Rosen, Laris, & Kim, 2004; NAMI Policy Research Institute, 2003).

INDICATORS

A) Development of crisis plans employing progression of interventions designed to de-escalate volatile situations
B) Constraint of individuals presenting clear threats to their own or other's safety and welfare is guided by both individualized plans and agency policy.
C) Debriefing occurs after all incidents requiring restraint or seclusion.
D) All staff potentially able to respond to a volatile incident are trained in de-escalating techniques and alternatives to forceful constraint.

Supports

Advocacy and Mutual Support. Facilitation of contact with and participation in consumer advocacy groups and mutual support

programs is an important aspect of ROS. Liaison with entities involved in these activities should be established to enable this process. Intensive community based peer mentoring/sponsorship programs, consumer managed peer support networks and drop-in centers are examples of these services (Carling, 1995; Chinman, Weingarten, Stayner, & Davidson, 2001; Cheung & Sun, 2001; Fisher, 1994a; Kurtz, 1990; Mowbray et al., 1996; Rootes & Aanes, 1992).

INDICATORS

A) Active facilitation of participation of clients in advocacy organizations is demonstrated.
B) An agency liaison with local advocacy and support groups is identified and active.
C) Majority of consumers participate in peer support activities.

Access Facilitating Processes. Development of resources available to improve access to services should include, but should not be limited to communication aids (language accommodation), child care, transportation, mobile services and pharmacy, collaborative relationships with primary care providers, and an ombudsperson to address other barriers to access (Lehman et al., 2002; Onken et al., 2002; Roth et al., 1999).

INDICATORS

A) Agency records will reflect liaisons with agencies providing access related services.
B) Effective processes in place to obtain services for persons who are not adequately insured or otherwise unable to access existing services financially.
C) Completion of access analysis identifying systemic barriers to receiving services.
D) Service users report satisfaction with their access to services they have chosen.

Family Services. Family education and empowerment activities supportive of recovery principles will strengthen attempts by consumers to establish recovery and should be developed by providers of recovery-oriented services. By broadening family members' under-

standing of recovery processes and their role in fostering autonomy and growth in disabled loved ones, they can be engaged to develop coping skills and to become active supports to a consumer's efforts to enter and maintain recovery (Baxter & Diehl, 1998; Mueser et al., 2002; Onken et al., 2002; Pitschel-Walz et al., 2001).

INDICATORS

A) Family involvement in agencies will be reflected in educational, social and advocacy programming by the agency.
B) Liaison and collaboration with advocacy groups will be reflected in family oriented programming.
C) Incorporation of family participants in treatment team and planning processes (when desired by consumer).
D) Family psycho-education provided for clients with some family involvement.

Employment and Education. A full array of training, education and employment opportunities should be available to consumers who wish to broaden their experience and independence. Developing skills and putting them to use is often one of the most self-affirming and confidence enhancing activities that recovering persons can engage in. ROS will support the aspirations of consumers and guide them to processes for achieving them rather than dismissing such aspirations as unrealistic (Carlson, Rapp, & McDiarmid, 2001; Lehman et al., 2002; Onken et al., 2002; Roth et al., 1999).

INDICATORS

A) Development of a substantial array of employment and training opportunities with various levels of support for these activities.
B) Consumers experience support for their vocational choices and assistance in pursuing them.
C) Process for vocational counseling and support is integrated with other aspects of the recovery process.
D) Individualized placement and support is predominant approach to vocational rehabilitation.

Housing. A full array of independent living and supported housing options should be available to consumers and efforts should be made to support the consumer's preferences regarding their living situation. Housing which is tolerant and which makes few demands upon residents should be available (AACP 2001; Onken et al., 2002; Tsemberis, Gulcur, & Nakae, 2004).

INDICATORS

A) Consumers express satisfaction with available housing options.
B) Consumers feel that their housing preferences are respected and accommodated to the greatest extent possible.
C) A full array of housing options are available including various tolerant housing options.
D) All housing options support independence, choice and progression.

CONCLUSION

The process that was described for the development of these guidelines confers significant face validity to their application. Whether these guidelines constitute evidence based practice will depend on how one defines evidence (Friese et al., 2001). In the broadest sense of the concept, these practices do qualify as such. It is clear though, that a recovery orientation is more than a set of interventions designed to impact narrowly defined outcomes of service participation. Recovery oriented services represent a philosophical approach to service provision that complements whatever other specific intervention or protocol that may be provided to ameliorate the symptoms of illness. As such, they represent a set of values that should govern human services and clinical relations and therefore have virtue beyond tangible or observable outcomes. However, a review of the literature indicates that several of the elements included in these guidelines do, in fact, enhance the quality of life for persons with behavioral disabilities, and many would consider this outcome of greatest importance. Significant opportunities exist to investigate the various elements of these guidelines to determine their impact on those who suffer from mental health and addictive disorders.

The establishment of recovery-oriented services will require a transformation of the way professionals have been trained to think about their roles. This re-conceptualization will include an understanding that the helper's role should be facilitative rather than directive, hope inspiring rather than pessimistic, and autonomy enhancing

rather than paternalistic, to help every individual reach their full potential. Use of these guidelines should be collaborative rather than autocratic. Recovery oriented services will enhance organization's capacity to assess their own progress in establishing ROS and to begin the process of establishing measurable indicators for quality monitoring. The guidelines will also be useful to larger systems and regulatory agencies in developing standards and establishing accountability and should be useful to consumer advocacy groups in their attempts to assist the transformation of traditional systems of care.

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